Eligible Professionals User Manual Electronic Health Records Incentive Program

Idaho Department of Health and Welfare Division of Medicaid



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PART I: PROGRAM OVERVIEW

Purpose

The purpose of this manual is to provide eligible professionals (EPs) with an overview of the Idaho Medicaid Electronic Health Records (EHR) Incentive Program, information about what needs to be done to receive payments, and step-by-step instructions about how to enroll and attest.

Introduction

Through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), the Centers for Medicare & Medicaid Services (CMS) has implemented incentive payments to EPs that are participating in Medicare and Medicaid programs and are meaningful users of certified EHR technology. The incentive payments are not a reimbursement, but are intended to encourage EPs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator (ONC) for Health Information Technology has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at http://www.healthit.hhs.gov.

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines; and 4) enable data sharing using the state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce the costs of health care nationwide. Idaho Medicaid staff will work closely with federal and state partners to ensure the Idaho Medicaid EHR Incentive Program fits into the overall strategic plan for the Idaho HIE, thereby advancing Idaho and national goals for HIE.

Eligibility

A provider's eligibility to receive EHR incentive payments is based on the provider type and specialty, patient volume, state of licensure and good standing, and verification that a qualifying EHR system has been adopted, implemented or upgraded (for AIU) and the provider is meaningfully using it (for MU).

Provider Type and Specialty

The first tier of provider eligibility for the Idaho Medicaid EHR Incentive Program is based on provider type and specialty. At this time, CMS has determined that the following providers are potentially eligible to enroll in the Idaho Medicaid EHR Incentive Program:

- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Advanced Practice Professional Nurses
 - Certified nurse-midwives
 - Nurse Practitioners
 - Clinical Nurse Specialists
 - Registered Nurse Anesthetists

- Dentists
- Physician assistants who furnish services in a federally qualified health center (FQHC) or rural health clinic (RHC) that is led by a physician assistant

The EHR incentive payments will only be made to Idaho Medicaid providers (EPs with an Idaho Medicaid Provider Agreement), unless the provider predominantly practices in an RHC or FQHC.

Patient Volume

Patient volume thresholds must be established every year a provider applies for an incentive payment. To qualify for an EHR incentive payment for each year the EP seeks the incentive payment, the EP must not be hospital-based (hospital-based means an EP who furnishes 90 percent or more of covered professional services in a hospital, inpatient, or emergency room setting (POS 21 and 23) in the calendar year or rolling calendar year preceding the payment year) and must meet one of the following patient volume criteria:

- Have a minimum of 30 percent Medicaid patient volume attributable to individuals receiving Medicaid funded services.
- Have a minimum of 20 percent patient volume attributable to individuals receiving Medicaid funded services **and** be a pediatrician.
- Practice predominantly in an FQHC or RHC and have a minimum of 30 percent patient volume attributable to needy individuals.
 - To practice predominantly means an EP for whom the clinical location for over 50 percent of his or her total patient encounters over a period of six months in the most recent calendar year or a rolling 12 months period prior to attestation occurs at an FQHC or RHC. In Idaho, the most recent calendar year is defined as the previous completed calendar year and a rolling 12 month calendar is any 12 months preceding attestation. This is a statutory requirement that is not subject to the interpretation of the state. If an FQHC or RHC must use non-Medicaid encounters to reach the minimum 30 percent threshold, an EP hired in the current calendar year should have the appropriate track record for a six month period in the previous calendar year or rolling 12 month calendar. This attestation will be subject to post-payment audit. Examples of non-eligible professionals include:
 - A doctor who is on staff at the FQHC but who was on sabbatical last year and didn't practice at all.
 - A new EP whose last job in the previous calendar year was at a university medical center.
 - A staff EP who performed only 1-49 percent of his or her encounters at an FQHC last year.
 - o Services attributable to needy individuals are defined as those that meet one of the following:
 - Services rendered to an individual who is receiving assistance under Title XIX, who is receiving
 assistance under Title XXI, who is furnished uncompensated care by the provider, or for whom
 charges are reduced by the provider on a sliding scale based on the individual's ability to pay.
 - Services rendered on any one day to an individual where Medicaid or the Children's Health
 Insurance Program (CHIP) or a Medicaid or CHIP demonstration project under section 1115 of
 the Social Security Act paid all or part of their premiums, co-payments, or cost sharing.
 - Services rendered to an individual on any one day that were on a sliding scale or that were charity care.

CHIP Encounters for Patient Volume and Payment Calculation

Encounters with Medicaid participants receiving services funded by Title XXI **cannot** be included in the patient volume calculation unless the EP practices predominantly in an FQHC or RHC **and** is basing the patient volume on needy patient encounters. Because EPs can't always distinguish between funding sources, Idaho Medicaid has received permission from CMS to use a "CHIP patient volume average" strategy to help EPs determine their Medicaid patient volume.

Idaho's payment system differentiates the paying source using detailed codes for eligibility that are traceable to the claim. Using this information, Idaho Medicaid has identified a statewide average proportion for CHIP encounters for professionals. The CHIP patient volume average is currently seven percent. The CHIP patient volume average was reviewed again in 2013, and it was determined to still be seven percent, therefore, there will be no change in the current methodology for determining CHIP patient encounters. This is based on an analysis of three years of claims history. This percent gives the statewide average of CHIP-to-total Medicaid encounters. Eligible professionals must identify their total number of Medicaid encounters and reduce that by the CHIP patient volume average percent when applying for incentives.

Using this method will benefit some providers whose actual CHIP patient encounters are higher than the statewide average, and may disadvantage those whose CHIP volume is lower than average. Idaho Medicaid wants to work with EPs to ensure that they are not falsely denied eligibility based on this strategy. Providers can request the state provide them with the **actual** number of Medicaid and CHIP encounters for the 90-day period of their choosing **if** they are unable to meet the patient volume threshold with the CHIP patient volume average reduction and believe that they could meet it otherwise. Medicaid staff will give the number to the provider making the request. Professionals can contact the Idaho Medicaid EHR Incentive Program Help Desk staff at (208) 332-7989 for more information about this process.

Eligible Professionals Patient Volume Calculator

To calculate Medicaid patient volume, EPs who are not practicing predominantly in an FQHC or RHC must divide:

- The total Medicaid patient encounters in any representative, continuous 90-day calendar period in the preceding calendar year or rolling 12 month calendar prior to attestation reduced by the seven percent CHIP average; by
- The total patient encounters in the same 90-day period.

To calculate Medicaid patient volume, EPs practicing predominantly in an FQHC or RHC and basing patient volume on needy encounters must divide:

- The total needy individual patient encounters in any representative, continuous 90-day period in the preceding calendar year or rolling 12 month calendar prior to attestation; by
- The total patient encounters in the same 90-day period.

Medicaid will count all eligible encounters including zero dollar paid claims. Medicaid will also include any claim for a Medicare dual eligible.

Statewide Average for CHIP and Impact on Auditing

For EPs that are audited and have used the CHIP patient volume average, the auditor will assess whether the total Idaho Medicaid encounters were accurately represented and will not attempt to evaluate an EP's actual Medicaid-only encounters. There would be no penalty for EPs who have an actual CHIP patient volume higher than the statewide patient volume average. For EPs who request their specific data, the audit will assess whether the Medicaid-only encounters were accurately represented, given the information provided by the state.

Group Proxy Calculation

The Idaho Medicaid EHR Incentive Program has developed a group proxy roster calculation worksheet to help facilitate consistent attestation of patient volumes by eligible professionals and to streamline patient volume verification. It is important for EPs to remember that:

- The entity responsible for the group must complete a group proxy roster calculation worksheet and make it available to all EPs.
- Every EP must upload a copy of the group proxy roster calculation worksheet and its supporting patient encounter report during the application/attestation process for the Idaho Incentive Management System (IIMS).
 - **Note:** The 90-day patient encounter report of needy/total patient encounters is required to support the proxy calculation.
- A new group proxy calculation worksheet must be completed every year and for each phase of the
 program (e.g., AIU, meaningful use Stage 1, etc.) the group's EPs apply for a Medicaid incentive if using
 the group proxy calculation approach that year.

The group proxy calculation can be set at the organizational level or the clinic level. If using an organizational level proxy calculation, the clinics that are included cannot be an arbitrary group of clinics to maximize patient volumes. An organizational level proxy must include all of the organization's clinics that are within the state of Idaho. **No out-of-state clinics will be allowed to be included in the proxy.**

After the group proxy calculation worksheet is completed, it needs to be converted to a PDF format and uploaded during application/attestation in the IIMS.

Institutional License and Good Standing

All participating EPs must have a current institutional license (provisional licenses will be accepted) and must be free of both state- and federal-level sanctions and exclusions to be eligible for incentive payments.

Adopt, Implement, or Upgrade

All EPs must verify that they have adopted, implemented, or upgraded to a certified EHR system. Below are the criteria for each:

Adopt: "acquire, purchase, or secure access to certified EHR technology."
 There is evidence that an EP demonstrated actual installation prior to the incentive, rather than "efforts" to install. This evidence serves to differentiate between activities that may not result in installation (e.g., researching EHRs or interviewing EHR vendors) and actual purchase/acquisition or installation.

- Implement: "install or commence utilization of certified EHR technology." The EP has installed certified EHR technology and has started using the certified EHR technology in his or her clinical practice. Implementation activities would include staff training in the certified EHR technology, the data entry of their patients' demographic data into the EHR, or establishing data exchange agreements and relationships between the EP's certified EHR technology and other EPs, such as laboratories and pharmacies.
- Upgrade: "expand the available functionality of certified EHR technology."
 The EP has added clinical decision support, electronic prescribing functionality, or other enhancements that facilitate the meaningful use of certified EHR technology. An example of upgrading that would qualify for the EHR incentive payment would be upgrading from an existing EHR to a newer version that is certified per the EHR certification criteria promulgated by the ONC related to meaningful use.
 Upgrading may also mean expanding the functionality of an EHR to ensure that the practice location has certified electronic health record technology (CEHRT) that is listed on the ONC's Certified Health IT Product List (CHPL) site.

Please see the "Preparing the Documentation Required for Attestation" section of this handbook for details about what documentation will be required as proof of AIU.

Getting Your EHR Certification

The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology. Standards, implementation specifications, and certification criteria for EHR technology have been adopted by the Secretary of the Department of Health and Human Services. The EHR technology in use by the EP must be tested and certified by an ONC Authorized Testing and Certification Body (ATCB) in order for that EP to qualify for EHR incentive payments. Once certified, the product is listed on the ONC's website, often referred to as the Certified Health IT Product List (CHPL), where an EP must obtain a unique CMS EHR Certification ID Number. This certification number must be provided as part of the attestation process for either the Medicare or Medicaid incentive program.

Eligible professionals can obtain the CMS EHR Certification ID Number for their EHR product by following these steps:

- 1. Go to the ONC CHPL website: http://healthit.hhs.gov/chpl.
- 2. Select the practice type by selecting either the "Ambulatory" or "Inpatient" button.
- 3. Search for EHR products by browsing all products, searching by product name, or searching by criteria.
- 4. Add products to your cart to determine if they meet 100 percent of the CMS required criteria.
- 5. Request a CMS EHR Certification ID Number for CMS attestation (this number should contain 15 alphanumeric characters).

Note: The "Get CMS EHR Certification ID" button will not be activated until the products in your cart meet 100 percent of the CMS required criteria. If the EHR products don't meet 100 percent of the CMS required criteria to demonstrate meaningful use, a CMS EHR Certification ID Number will not be issued.

Important Clarifications

The ONC CHPL Product Number issued to your vendor for each certified technology is different than
the CMS EHR Certification ID Number issued to an EP for registration and attestation purposes. Only a
CMS EHR Certification ID Number (obtained from the CHPL site) that is unique to the practice will be
accepted at attestation.

- It is not enough for a provider's EHR product to be certified by the Certification Commission for Health Information Technology (more commonly known as CCHIT certification). The product must be certified by an ONC-ATCB specifically for the Medicare and Medicaid EHR Incentive Programs and listed on the ONC's website.
- An EP doesn't need to have a certified EHR technology in place to register with CMS for the Medicare
 and Medicaid EHR Incentive Programs. However, the EP must adopt, implement, or upgrade to a
 certified EHR system under the Medicaid EHR Incentive Program or successfully demonstrate
 meaningful use of certified EHR technology under the Medicaid EHR Incentive Program before the EP
 can receive an EHR incentive payment.

The ONC's website of certified products has the final rules related to certification standards, fact sheets, frequently asked questions, a list of ONC-ATCBs, and a wealth of information about certified products and obtaining certification.

Special Eligibility Issues for FQHCs and RHCs

The EPs that practice at FQHCs and RHCs encounter special eligibility issues other EPs do not.

Physician Assistants

Unlike other eligible provider types, physician assistants (PAs) can apply for an EHR incentive only if they are practicing at an FQHC or RHC that is led by a PA. The definition of PA leadership is the key to PA eligibility.

In the Medicare and Medicaid EHR Incentive Program Final Rule p. 44483, CMS interprets the statutory language regarding "PA-led" as follows:

"We believe a PA would be leading an FQHC or RHC under any of the following circumstances:

- When a PA is the primary provider in a clinic (for example, when there is a parttime physician and full-time PA, we would consider the PA as the primary provider);
- 2) When a PA is a clinical or medical director at a clinical site of practice; or
- 3) When a PA is an owner of an RHC.

We agree that FQHCs and RHCs that have PAs in these leadership roles can be considered PA-led. Furthermore, since RHCs can be practitioner owned (FQHCs cannot), we will allow ownership to be considered PA-led."

Circumstances (2) and (3) above can usually be validated with internal data, public documents, and even clinic websites. Circumstance (1), in which a PA is the primary provider, is more difficult and cumbersome to authenticate, especially given the simplicity of the CMS example. In some cases - for instance, when full-time PAs outnumber full-time physicians, or a small rural clinic has only a single EP - primary providership may be easily established. To avoid making improper payments in cases that are less clear, the state will request dated, documented evidence from FQHCs and RHCs from which one or more PAs apply. Documentation might include position descriptions, work schedules, appointment calendars, emails, meeting minutes, and other organizational documents that yield conclusive indications of clinical leadership.

CMS has offered the following guidance to FQHCs and RHCs as they evaluate if the clinic is PA-led when a PA does not have the title of Medical Director. Consider if the PA:

- Sets the amount of clinical time and administrative time for the other EPs.
- Reviews and signs the policies and procedures for clinical practices.
- Sets the schedule for the other EPs.
- Leads the EP meetings.
- Sets quality goals for the clinic.
- Completes performance evaluations for the other EPs.

Payments

How to Become a Vendor With the State

Idaho Medicaid is using the state fiscal system to set up financial transactions for incentive payments. This fiscal system is <u>not</u> the same payment system that is used to process Medicaid payments to current EPs. Providers will need to ensure they are enrolled as a vendor in this system in order to receive payments. If EPs are unsure of prior vendor enrollment, they can call the Idaho Medicaid EHR Incentive Program Help Desk at (208) 332-7989 to see if they have previously enrolled.

 To enroll as a vendor who receives paper checks and paper remittance advices (RAs), the EP must complete a W-9 form (http://www.irs.gov/pub/irs-pdf/fw9.pdf) and submit it to the Idaho Medicaid EHR Incentive Program using one of three methods:

Mail: EHR Incentive Payments Fax: (208) 334-6515

Division of Medicaid PO Box 83720

Boise, ID 83720-0009 Email: EHRIncentives@dhw.idaho.gov

To enroll as a vendor who receives direct deposits (EFT), the EP must complete the <u>Combined</u>
 <u>Substitute W-9/EFT Direct Deposit Authorization Form</u> (on the Idaho Office of the State Controller's website). This form must be **mailed** along with a voided check (originals only, copies/faxes/scanned documents will not be accepted) to:

EHR Incentive Payments Division of Medicaid PO Box 83720 Boise, ID 83720-0009 *Do not mail completed form and voided check to the address at the top of this form. It will delay processing.

Processing of the completed EFT form includes verifying the vendor's tax identification number (TIN) and name with the IRS to make sure they match, and verifying the vendor's financial institution. This process usually takes a few weeks. Once the submitted EFT paperwork and voided check have been processed, the controller's office sends the EP a letter or email with their logon information, password, and instructions for accessing the state controller's vendor website so the EP can view the RAs.

Note: EPs who sign up for EFT will not receive paper checks or paper RAs. If an EP is reassigning payment, the clinic or group to whom the payment is reassigned must be enrolled as a vendor with the state of Idaho and follow the instructions above to receive a paper check or EFT.

Understanding Payment Timelines

The maximum incentive payment an EP can receive from Idaho Medicaid equals \$63,750 over a period of six years, or \$42,500 for pediatricians with a 20-29 percent CMS patient volume as shown below.

Provider	EP: Patient Volume 30 Percent	EP-Pediatrician (Medicaid): 20-29 Percent
Year 1	\$21,250	\$14,167
Year 2	\$8,500	\$5,667
Year 3	\$8,500	\$5,667
Year 4	\$8,500	\$5,667
Year 5	\$8,500	\$5,667
Year 6	\$8,500	\$5,667
Total Incentive	\$63,750	\$42,500

Pediatricians may qualify to receive the full incentive if they can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirements. In Idaho, a pediatrician will be considered any physician whose National Provider Identifier (NPI) is associated with a pediatric taxonomy code, including specialties, all of which begin with 2080. In addition, any physician who predominantly treats individuals under 21 years of age and believes the above definition will negatively impact potential eligibility can contact the program eligibility specialist to discuss verification for pediatric focus.

Note: EPs must reapply to Medicaid and demonstrate volume thresholds each year they wish to receive a payment.

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than calendar year 2016. EPs can choose to receive the EHR payment **or** choose to reassign the payment to a Medicaid contracted clinic or group to which the EP is associated. This decision must be made when the EP registers with the CMS EHR Registration and Attestation (R&A) website. The TIN of the individual or entity receiving the incentive payment is required when registering with CMS and must be associated to a TIN linked to the individual EP in the IIMS. All EPs who assign payment to themselves (and not a group or clinic) will be required to provide Idaho Medicaid with updated information.

Note: If Idaho Medicaid determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS.

Out-of-State Providers

The EHR incentive payments will only be made to Idaho Medicaid providers (EPs with an Idaho Medicaid Provider Agreement), unless they predominantly practice in an RHC or FQHC.

Program Integrity and Audit

Idaho Medicaid will conduct regular reviews of attestations and incentive payments. These reviews will be selected as part of the current audit selection process, including risk assessment, receipt of a complaint, or incorporation into reviews selected for other objectives. EPs must keep their supporting documentation for six years after each payment is received.

Administrative Appeals

EPs can choose to appeal the determination made by the Idaho Medicaid EHR Incentive Program about the incentive payment application. All contested cases are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings".

Meaningful Use

Clinical Quality Measures

Clinical quality measures (CQM) are tools that help measure and track the quality of health care services provided by EPs, eligible hospitals, and critical access hospitals within our health care system. These measures use a wide variety of data that are associated with a provider's ability to deliver high-quality care or relate to long-term goals for health care quality. The CQMs gauge many aspects of patient care including health outcomes, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagements, population, public health, and clinical guidelines. Continuously measuring and reporting these CQMs helps to ensure that our health care system can deliver effective, safe, efficient, patient-centered, equitable, and timely care.

Requirements

Meaningful use includes both a core set and a menu set of objectives that are specific to EPs. For EPs who are participating in Stage 1, there are a total of 23 meaningful use objectives. To qualify for an incentive payment, 18 of these 23 meaningful use objectives must be met: 13 required core objectives and 5 objectives chosen from a list of 9 menu set objectives. Stage 2 providers will have to meet 20 meaningful use objectives out of 23 objectives: 17 required core objectives and 3 objectives chosen form a list of 6 menu objectives.

In addition to meeting the core and menu objectives, EPs are also required to report CQMs. All EPs must report on 9 total CQMs selected from a set of 64 CQMs from at least 3 domains out of 6 domains in order to receive an incentive payment from the Idaho Medicaid EHR Incentive Program.

Provider Attestation Process and Validation

It is the policy of Idaho Medicaid that EPs may permit an authorized representative to complete the CMS registration and Idaho application/attestation forms on behalf of an EP. For instructions on how to act on behalf of an EP, go to the CMS Registration and Attestation website (http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html). The following is a description of information that must be reported or attested to during the process:

- After registering for the incentive program on the CMS EHR R&A website at
 http://www.cms.gov/EHRIncentivePrograms/, Idaho Medicaid will receive notification of
 registration from CMS. Idaho Medicaid will do some pre-verification and then contact the EP using
 the contact information provided to CMS. The EP will be given the link to the IIMS where the EP
 can log in to begin the application/attestation process. To log into the IIMS, the EP will need the EP
 NPI and CMS EHR Registration ID Number.
- The EP will then be asked to view the information that is displayed with the pre-populated data received from the CMS EHR R&A process.
- EPs will then be asked to enter the patient volume characteristics and EHR details.

The EP will be asked to attest to:

- Assigning the incentive payment to a specific TIN, if applicable (the name of the EP and the TIN to which the payment was assigned will be displayed).
- Not working as a hospital-based professional (this will be verified by Idaho Medicaid through claims analysis).
- Not applying for an incentive payment from another state or Medicare.
- Not applying for an incentive payment under another Idaho Medicaid ID Number.
- Adopting, implementing, or upgrading the certified EHR technology.

Once the electronic attestation is submitted by a qualifying EP or authorized representative and appropriate documentation provided, Idaho Medicaid will conduct a review that will include cross-checking for potential duplication payment requests, checking EP exclusion lists, and verifying supporting documentation.

The attestation itself is electronic and will require the EP to attest to meeting all requirements defined in the federal regulations. Some documentation must be provided to support specific elements of attestation. All EPs are required to submit supporting documentation for patient volume claimed in the attestation. More information on documentation is provided in the IIMS.

Meaningful use of certified electronic technology is designed to happen in stages and the clinical quality measures tied to meaningful use will change over time. The state of Idaho will revise this provider user manual as the rules and measures change over time.

Preparing the Documentation Required for Attestation

The following is a description of the documentation that an EP must upload to the IIMS (https://IIMS.dhw.idaho.gov) during attestation:

Adopt, Implement or Upgrade (AIU) documentation

- Proof of adopting, implementing, or upgrading to certified EHR technology this must be a document showing a binding agreement between the EP (or the healthcare organization) and the EHR vendor, such as a contract between entities. Idaho Medicaid only needs the most current documents for proof, not all historical documents relating to the EHR system.
- An invoice showing payment or acquisition for the certified EHR system (actual numbers may be blacked out).
- A purchase order (only for AIU).
 - **Note:** A vendor letter is not acceptable unless submitted with additional binding documentation. The documentation submitted must include the exact name of the EHR system including the software version number.
- A provider group proxy (if applicable).
- PA-led documentation (if applicable). Refer to Physicians Assistants under Special Eligibility Issues for FQHCs and RHCs for acceptable documentation.

- ONC/CHPL confirmation email or screen shot showing CEHRT number.
- A patient volume encounter report in the Idaho Medicaid EHR Incentive Program, all EPs are required to submit a 90-day patient volume report to support their attestation for Medicaid or needy patient encounters. The report must be from an auditable source and system generated from the practice's administrative or clinic care system. The content of the report is intended to provide the state sufficient information to validate patient encounters reported. The particular format of the report is not as important as the content; however, it will be important to make the content clear on the report by using headings and labels. The following are definitions of the content we require on the report:
 - Date: The date the report was generated.
 - 90-Day Period: The start and end date of the 90 calendar days used to determine patient volume. Please use the most recently completed calendar year (12 month period: January-December) prior to the year you are completing or a rolling calendar year (12 months prior to attesting) to complete the application/attestation. Idaho will allow you to use an additional three months after the calendar year, called the "tail period," if you need to use this time frame to complete your attestation.
 - Name of EP: The name of the individual EP or, if an EP is using a clinic/group proxy calculation, the name of the clinic/group.
 - Provider NPI: The NPI for all of the eligible providers included in the report. Every encounter must have an NPI if it is a service provided by an EP. If the report is to support a group proxy patient volume calculation, the report will list all encounters of all practitioners. Medicaid understands that some non-eligible practitioners may not have an NPI.
 - Clinic NPI: The NPI for the clinic that is connected to this EP or group of EPs, if using the group
 proxy approach for establishing patient volume.
 - Total Medicaid or Needy Encounters: The total number of Medicaid or needy encounters attributable to the EP or, if using a group proxy calculation, all practitioners at the clinic/group practice. The report could show daily, weekly, or monthly sub-totals if the EP desires. If the report includes out-of-state Medicaid/needy encounters, they must be identified and included in both the numerator and the denominator for the patient volume calculation.
 - Total Patient Encounters: The total number of patient encounters attributable to the EP or, if using a group proxy calculation, all practitioners at the clinic/group practice. If the report includes out-of-state Medicaid/needy encounters, they must be identified and included in both the numerator and the denominator for the patient volume calculation. Claims that are billed as a global service are counted as one encounter in the numerator and denominator for all payer sources. Note: If providers have out-of-state encounters for the period, they may include them in their encounters only if this is needed to meet the patient volume threshold. When using out-of-state encounters, include these numbers in both the "Total Medicaid" or "Needy Encounters" and the "Total Patient Encounters". Identify the state and total encounters separately in these totals to provide visibility to these numbers.
- Meaningful use documentation
 - Core Measures: One screen shot from the certified EHR software that was used for a core attestation item.

- Menu Measures: One screen shot from the certified EHR software that was used for a menu attestation item.
- Clinical Quality Measures: One screen shot from the certified EHR software that was used for a clinical quality measure attestation item.
- Patient volume encounter report see requirements in AIU section above
- A provider group proxy roster (if applicable).
- PA-led documentation (if applicable). Refer to Physicians Assistants under Special Eligibility Issues for FQHCs and RHCs for acceptable documentation.
- ONC/CHPL confirmation email or screen shot showing CEHRT number.
- Current EHR documentation (user's license invoice, maintenance invoice, letter from vendor-only for MU, etc.)

When naming your document, please use the following naming conventions:

- For core measures use the EP's last name, core number (in IIMS) you are attesting to, and date (e.g., smith_mucore6_mmddyy).
- For menu measures use the EP's last name, menu number (in IIMS) you are attesting to, and date (e.g., smith_mumenu8_mmddyy).
- For clinical quality measures use the EP's last name, clinical quality measure number (assigned by CMS and in IIMS) you are attesting to, and date (e.g., smith NQF0024 mmddyy).

PART II: STEP BY STEP INSTRUCTIONS

Overview

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs are staged in three steps with increasing requirements for participation. All providers begin participating by meeting the Stage 1 requirements for a 90-day period in their first year of meaningful use (MU) and a full year in their second year of MU, except in 2014. The reporting period for 2014, regardless of the stage, is 90 days due to EHR system upgrade requirements by the Centers for Medicare and Medicaid Services (CMS). After meeting the Stage 1 requirements, providers will have to meet Stage 2 requirements for two full years. All eligible professionals (EPs) participate in the program according to calendar years, while eligible hospitals and critical access hospitals participate according to the federal fiscal year. Idaho has implemented a webbased interface, called the Idaho Incentive Management System (IIMS), for providers to apply and attest at the Idaho state level. To successfully use the IIMS to apply and attest, you must:

- Be successfully registered on the CMS website for the EHR Incentive program.
- Have the following information available:
 - o The National Provider Identifier (NPI) you used to register at the CMS website.
 - The CMS Registration Identification Number that is associated with your NPI (provided by CMS during registration).
 - Supporting documentation on patient volume, EHR details, and physician assistant led clinics (if applicable).

Steps to complete your application/attestation in the IIMS include:

- 1. Log into the IIMS.
- 2. Review the CMS registration data.
- 3. Enter the eligibility details.
- 4. Review the incentive payment calculation.
- 5. Upload supporting documentation.
- 6. Submit the application/attestation.

The log-in process and step-by-step instructions for application, attestation, and information verification are discussed on the following pages.

Menu Flow for Adopting, Implementing, or Upgrading and Meaningful Use

Below is a comparison between the adopting, implementing, or upgrading (AIU) attestation steps and the MU attestation steps. The step-by-step instructions are organized by steps in the attestation process for both types of attestations with specifics for AIU and/or MU.

Adopt, Implement, or Upgrade Steps	Meaningful Use Attestation Steps
1. Review the CMS information	Review the CMS information
2. Enter the eligibility details	2. Enter the eligibility details
3. Enter the Certified EHR Technology locations	Complete Meaningful Use Questionnaire
4. Review the incentive payment calculation	4. Review Summary of Menu Options
5. Upload supporting documentation	5. Complete Meaningful Use Core Questions
6. Submit the application/attestation	6. Complete Meaningful Use Menu
	7. Complete Clinical Quality Measures
	8. Review Summary of Measures
	9. Review the incentive payment calculation
	10. Upload supporting documentation
	11. Submit the application/attestation

Logging Into the IIMS

Begin the Idaho Medicaid EHR Incentive Program application and attestation process by accessing the IIMS at https://IIMS.dhw.idaho.gov.

The following page is displayed:

Idaho Medicaid



Estracy | Individuals with Disabilities Copyright © 2012 State of Idabo All rights reserved.

When this page appears:

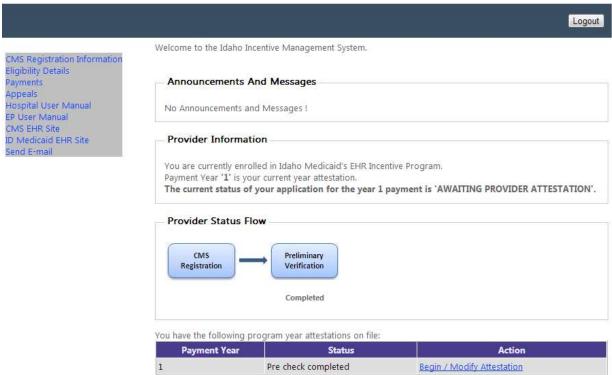
- Enter the NPI used when registering at the CMS EHR Incentive Program site and the 10 digit CMSassigned Registration ID Number. If the data entered here does not match the NPI or the CMSassigned Registration ID Number on file, the message "Invalid NPI/Registration ID combination" will be displayed.
- If you do not remember your CMS-assigned Registration Identification Number, you must return to the <u>Medicare & Medicaid EHR Incentive Program Registration and Attestation System</u> to reference it.
 If you cannot remember your password to the CMS site, contact the PECOS Help Desk at (866) 484-8049 or visit https://pecos.cms.hhs.gov for assistance.
- Select "Submit" to log in and proceed to the Idaho Medicaid IIMS landing page.

Adopt, Implement, or Upgrade Attestation

Adopt, Implement, or Upgrade Landing Page

After logging on, you will see the IIMS landing page (see graphic below). The current status of the payment year will be displayed in the "Provider Status Flow" section of the page.





To start the attestation process, you must select "Begin/Modify Attestation" and it will bring you to the CMS Registration Information page.

CMS Registration Information (AIU Step 1)





Some of the information on this page is for review only, but some information you'll need to provide. When this page appears:

- Review this information carefully. This information is populated directly from your CMS registration information. You cannot update the existing demographic information on this page. If you need to make updates to the demographic information, return to the CMS website and make your changes. Once you have completed your update on the CMS website, your information will again be sent to Idaho and this page will be updated. Please allow 24 hours for the update to be received by Idaho.
- Important Note: As you make your changes at the CMS website, make sure you go through all screens, selecting "Save" and "Continue", until you get to the Verify Registration page and select "Submit". Unless you select "Submit", your updated data will not be sent to Idaho, your status will be set to "In Progress at CMS" and your payment will likely be delayed.
- Select either "Yes" or "No" to answer the question, "Have you worked with WIREC?"
 Note: An answer is required.
- If you're licensed in Idaho, skip to step #4; if you are **NOT** licensed in Idaho:
 - Type the name of the state where you are licensed in the "State licensed in if not in Idaho" field (if you're not licensed in the state of Idaho, an answer is required).
 - Type the license number in the "Other State License" field (if you're not licensed in Idaho, an answer is required).
- Select "Next" to proceed to the Provider Eligibility Details page.

Provider Eligibility Details (AIU Step 2)

A graphic of the Provider Eligibility Details page is shown below. Use the step-by-step instructions below to complete this page.





Program Year:

Select the program year. This selection is only available if the current date is between January 1 and the end of March. This allows you to choose the previous program year during the three month period where you are allowed to attest for either program year. After the end of March, the program year will be defaulted to the current calendar year, which will be equal to the current active program year.

Patient Volume:

- 1. Select "Yes" or "No" from the drop down menu to indicate if your patient volume was calculated using the group proxy method.
- 2. If you answered "Yes", enter the NPI of the proxy entity (Idaho Medicaid will verify the NPI). If you entered "No", skip to question #3.
- 3. Select the starting date of the 90-day period to calculate the Medicaid/needy patient encounter volume percentage. If you do not enter a valid date, you will not be allowed to continue with attestation.

Note: The date must be a valid date within the previous calendar year or rolling calendar year to 90 days before the current date (January 1 to 90 days before the current date). This accommodates the EP's choice of using the previous calendar year or the most recent 12 months for the 90-day patient volume period.

4. Enter the Medicaid/needy patient encounters during this period.

Note: If using patient volume based only on Medicaid encounters, exclude seven percent for CHIP encounters. If you are basing patient volume on needy, disregard the exclusion of CHIP encounters. The following is an example for excluding CHIP encounters for patient volumes based on Medicaid:

- Total Medicaid encounters = 120
- Calculated CHIP amount based on seven percent state average: 8.4 and round to the nearest whole number 8
- Net Medicaid encounters: 120 8 = 112
- Result: use 112 for the Medicaid patient encounters
- 5. Enter the number of total patient encounters during this period.
- 6. There are two options for this question. Please read both options before completing this question.

Option #1: If you are basing your patient volume on needy encounters, select "Yes" from the drop down menu and answer question 6a when it appears (see graphic below). **Only FQHCs or RHCs can be based on needy; others must use Medicaid encounters.**

6a. Select "Yes" or "No" from the drop down menu to indicate if you practice predominantly at an FQHC or RHC (see graphic below). If you don't practice predominantly in an FQHC or RHC, you will not be allowed to continue with attestation.





Option #2: If you are not basing your patient volume on needy encounters, select "No" from the drop down menu and answer question 6b (see graphic below) when it appears.

6b. Use the drop down menu to indicate if you are **NOT** Hospital Based. If you are hospital based, you will not be allowed to continue with attestation.





7. Medicaid/needy patient volume percentage (calculated).

Note: When items #4 and #5 are entered and the cursor is moved to the next entry, the patient volume percentage is displayed.

The following edits with messages apply; if you do not meet these thresholds, you will not be allowed to continue with attestation:

- If the provider specialty is pediatrics and patient volume is based on Medicaid volumes but is below the 20 percent patient volume threshold, this message will be displayed: "x.xx% you must meet the threshold of 20% to get an EHR Incentive Payment".
- For other provider specialties (regardless of how patient volume is based) and those below the 30 percent patient volume threshold, this message will be displayed: "x.xx% you must meet the threshold of 30% to get an EHR Incentive Payment".

EHR Details:

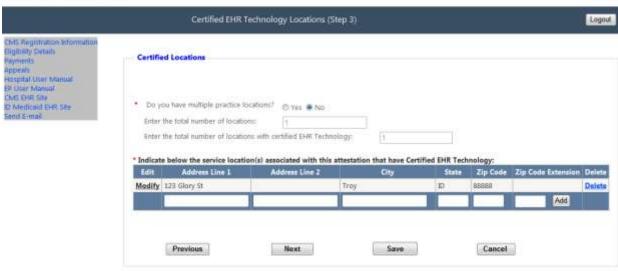
- 8. Enter the CMS EHR Certification ID of your EHR: This is your CMS EHR Certification ID, which will be auto-populated from your CMS registration information if it was provided there. If not, the EHR Certification ID must be input here. Only a valid ID will be allowed for you to continue your attestation.
- 9. Select the status of your EHR "Adopt", "Implement", or "Upgrade".

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" Will save your entries and take you to the Certified EHR Technology Locations page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel", you will see blank fields.

Certified EHR Technology Locations (AIU Step 3)





When this page appears:

- Select "Yes" or "No" to indicate if you have multiple practice locations.
- If you selected "Yes", enter the total number of locations (if you selected "No", the box will auto populate the number "1").
- Enter the total number of the locations indicated that have adopted, implemented, or upgraded to certified EHR technology.
- Use the table provided to fill in the address, city, state, and ZIP code for each service location indicated. **Note:** You may modify or delete your entries. Click "Add" after each location entered.

You will receive an error message if:

- You select "Yes" to indicate that you have multiple practice locations but leave **any** of the other fields blank (if you select "Yes", all fields on this page are required).
- The total number of locations with certified EHR technology is greater than the total number of service locations entered.
- The number of service locations that have certified EHR technology (the number entered in the second box) is different from the number of location addresses entered in the table (e.g., if you indicate that you have 5 service locations with certified EHR technology, you must enter 5 physical addresses into the table).

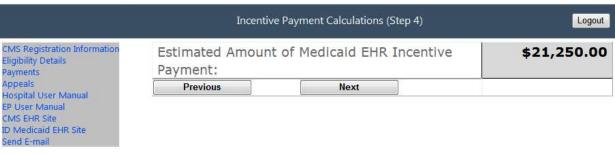
After entering your data, you must select one of the following buttons from the bottom of the screen:

 "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.

- "Next" Will save your entries and take you to the Incentive Payment Calculations page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel", you will see blank fields.

Incentive Payment Calculations (AIU Step 4)



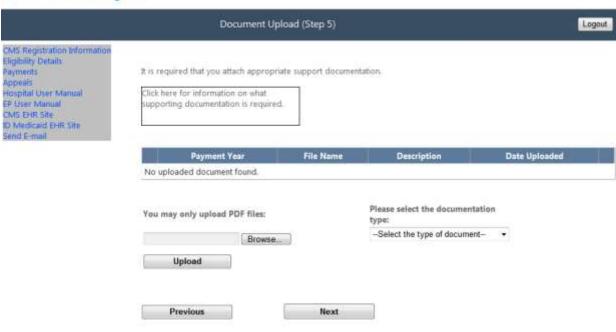


When this page appears:

- Review the incentive payment amount. Contact the Idaho Medicaid EHR Incentive Program Help Desk at EHRIncentives@dhw.idaho.gov or (208) 332-7989 if you have questions.
- If you see a \$0 estimated amount of Medicaid EHR incentive payment, you may not have met eligibility requirements; click on the "Previous" button, which will take you back to the Provider Eligibility Details page, and check your responses to the questions. If you have questions, contact the Idaho Medicaid EHR Incentive Help Desk.
- If your payment amount looks correct, select "Next" to go to the Document Upload page.

Document Upload (AIU Step 5)





When this page appears:

- If you have not already done so, you will need to upload the following documents:
 - Patient volume reports
 - o EHR documentation (receipt, canceled check, user agreement, etc.)
 - o Group Proxy Roster Worksheet (if applicable)
- You will still be able to upload files even after you have completed your attestation.
- Selecting "Next" will take you to the Attestation page of the IIMS.

Note: Only PDF files can be uploaded.

Attestation (AIU Step 6)





Previous

Required:

- Enter your initials or name and the provider's
 NPI at the bottom of the screen.
 - o This will serve as your electronic signature.
 - By entering this information, you attest to the validity of all data submitted for consideration by the Idaho Medicaid EHR Incentive Program.
- Select "Submit".

Important: After you select "Submit", YOU CANNOT GO BACK AND MAKE ANY CHANGES.

- Once you select "Submit", it will take you
 to the first page of your attestation, CMS
 Registration Information (Step 1), to
 review. You can select "Previous" and
 "Next" to view the attestation pages in a
 review mode only.
- Selecting "Submit" will notify Idaho
 Medicaid that the provider's attestation is ready for final eligibility review.

The attestation text is shown here:

ATTESTATION

FOR PARTICIPATION IN THE

IDAHO MEDICAID EHR INCENTIVE PROGRAM

This Attestation is required for participation in the Idaho Medicaid Electronic Health Record (EHR) Incentive Payment Program to eligible professionals (EPs) and eligible hospitals who adopt, implement, upgrade (AIU), or meaningfully use (MU) certified EHR technology. Participation must be in accordance with the requirements under United States Department of Health and Human Services, Centers for Medicare & Medicaid Services Final Rule regulations 42 CFR 495, "Standards for the Electronic Health Record Incentive Program", revised November 5, 2012. These regulations implement the HITECH Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5). To comply with the above cited regulations, the Idaho Department of Health and Welfare (Department) requires that EPs and eligible hospitals submit this Attestation.

This Attestation certifies the following is known and understood:

- 1. EPs are prohibited from seeking payment from another state or from the Medicare EHR incentive program in this payment year (applicable to EP only).
- 2. The Department can review, verify, and/or audit all information provided by the EP or eligible hospital, both prior to and after payment has been made.
- 3. The Department can request AIU and/or MU supporting information either at the time of attestation or after, and can review, verify, and/or audit both prior to and after payment has been made.
- 4. The EP or eligible hospital is required to retain the documentation that verifies patient volume calculations, AlU, MU, and any other information that validates the appropriateness of the EHR incentive payments received, and do so for six years from the date of payment.
- 5. The submission of any false information in this agreement or this process may result in the EP or eligible hospital being declared ineligible to participate in the Idaho Medicaid EHR Incentive Program.
- 6. Any incentive payments paid to the EP or eligible hospital that are later found to have been made based on fraudulent or inaccurate information or attestation may be recouped by the Department or other appropriate state or federal agency.
- 7. The EHR incentive payments will be treated like all other income and are subject to federal and state laws regarding income tax, wage garnishment, and debt recoupment.

This Attestation also certifies that the following is true and accurate:

- 1. With awareness and informed consent, this EP or eligible hospital is voluntarily participating in the Idaho Medicaid EHR Incentive Program.
- The EHR certification number provided is the correct number and accurately represents the certified EHR system or combination of certified EHR modules adopted and/or in use by this EP, group practice, or eligible hospital.
- 3. Any reassignment of an EHR incentive payment is made voluntarily, which assumes informed consent has been given by the EP, who understands that the party so designated—not the EP—will receive the payment (applicable to EPs only).
- 4. The person completing this electronic attestation is the EP or the assigned representative of the EP, group practice, or eligible hospital who has been duly authorized to commit the EP or eligible hospital to the statements set forth in this attestation (applicable to EPs only).
- 5. If patient volume threshold is derived using encounter data from multiple practice locations, at least one of those locations must have a certified EHR (applicable to EPs only).
- 6. If the EP is a physician assistant, he or she is practicing in a physician assistant led FQHC or RHC.

I CERTIFY THAT the information provided in this Attestation and during the registration process, as well as in the documents submitted in support of registration, are true, accurate, and complete. I hereby agree to retain such records for six years from the date of payment as are necessary to demonstrate I meet the program requirements, and to furnish those records to the Idaho Department of Health and Welfare, Division of Medicaid, or contractor acting on their behalf, upon request, before and/or after payment. I have read and understood this entire Attestation. I understand that any Medicaid EHR incentive payment made, in part or wholly as a result of this Attestation, will be from federal funds and that falsification or concealment of material facts may be prosecuted under federal and state laws.

Meaningful Use Attestation

The documentation that follows provides instructions for what the IIMS requires EPs to do in order to complete the MU attestation.

Helpful Tips:

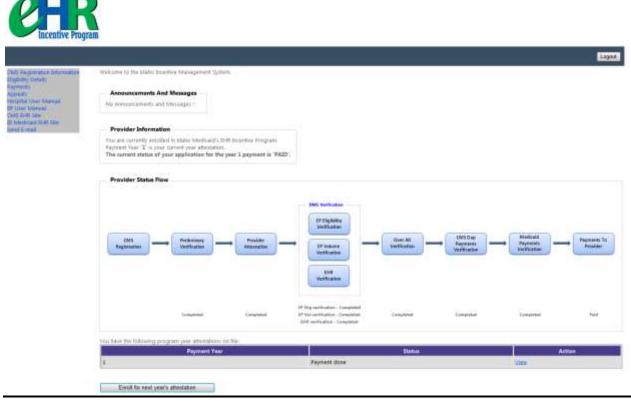
- Make sure your numbers are accurately entered when you attest.
- Keep your supporting documentation.
- Know that dated screen shots provide a good source of documentation.
- Save paper or electronic copies of reports used to attest if the practice's EHR automatically changes numerator and denominator values after the reporting period ends.
- Turn on, for the entire reporting period, EHR features that track functionality issues such as drug interaction checks and clinical decision support.
- Understand that the security risk analysis must be specific to the EHR and the practice and that it is required every year.

Meaningful Use Landing Page

After logging on, you will see the MU landing page (see graphic below). The current status of the payment year will be displayed in the "Provider Status Flow" section of the page.

You will see one of the following on the bottom of this page:

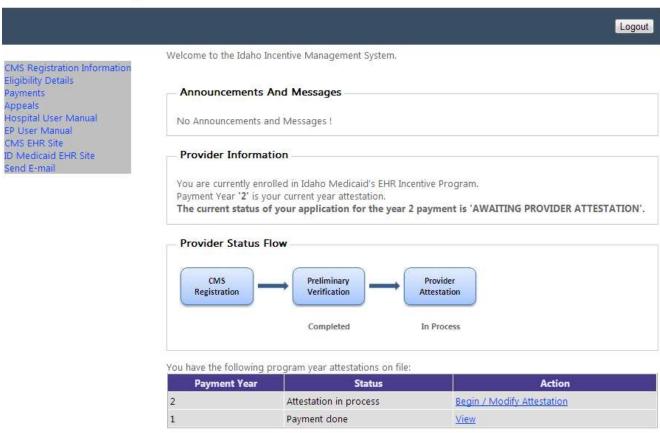
- The "Enroll for next year's attestation" button You will see this if you are already enrolled with the Idaho Medicaid EHR Incentive Program and have received a payment in the past (see graphic below).
- The "Begin/Modify Attestation" button under the "Action" column of the table shown You will see this link if you have **never** received a payment from the Idaho Medicaid EHR Incentive Program and your payment year is at least Year 2. This indicates that you are a new registrant to the Idaho Medicaid EHR Incentive Program and your CMS registration information has been reviewed by Idaho Medicaid.



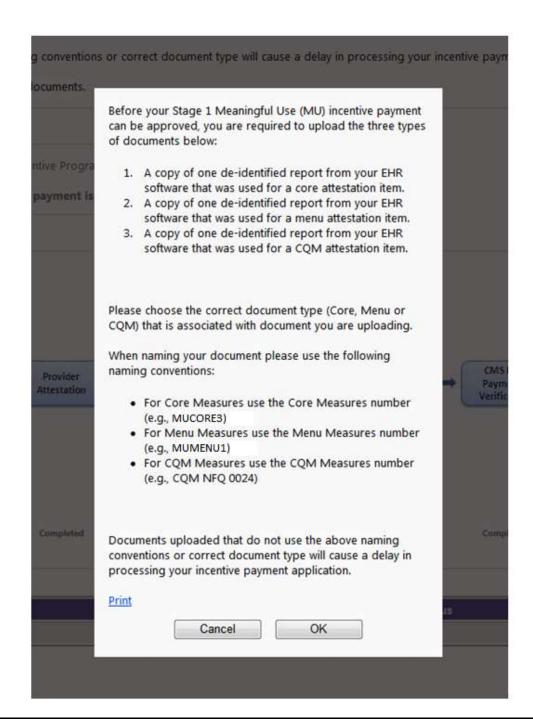
To enroll for the next year's attestation:

• Select the "Enroll for next year's attestation" button on the bottom of the page - the page will refresh and you will see a new payment year added to the table displayed (see graphic below).





• Select the "Begin/Modify Attestation" button – a new window will be displayed (see graphic below).



This is a message to all EPs that are attesting for MU. When this window appears, you must select one of the following buttons from the bottom of the screen:

- "Print" will bring up a separate browser window where the window contents can be printed for future reference.
- "Cancel" will close the window and return you to the previous page without enrolling you in the next year.
- "OK" will close the window, enroll you for the next year's attestation, and take you to the CMS Registration Information Page.

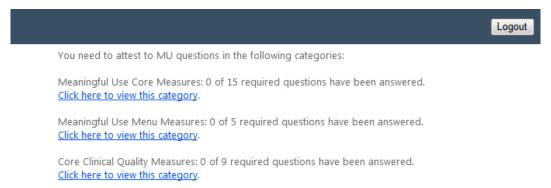
Important Note: Now that you have selected the "Begin/Modify Attestation" button, the following two links should appear on the left side menu to help you quickly access MU pages and resume attestation:

- "MU Attestation Progress" link will take you to the Summary of Menu Options page for MU (Step 4)
- "MU Summary" link will take you to the Summary of Measures page for MU (Step 9)

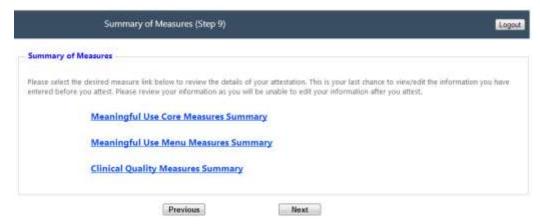




Selecting the "MU Attestation Progress" link shown above will take you to this page:



Selecting the "MU Summary" link shown above will take you to this page:



CMS Registration Information (MU Step 1)





Some of the information on this page is for review only, but some information you'll need to provide.

When this page appears:

- Review this information carefully. This information is populated directly from your CMS registration
 information. You cannot update the existing demographic information on this page. If you need to make
 updates to the demographic information, return to the CMS website and make your changes. Once you
 have completed your update on the CMS website, your information will again be sent to Idaho and this
 page will be updated. Please allow 24 hours for the update to be received by Idaho.
- Important Note: As you make your changes at the CMS website, make sure you go through all screens, selecting "Save" and "Continue", until you get to the Verify Registration page and select "Submit". <u>Unless you select "Submit"</u>, your updated data will not be sent to Idaho, your status will be set to "In Progress at CMS" and your payment will likely be delayed.
- Select either "Yes" or "No" to answer the question, "Have you worked with WIREC?"
 Note: An answer is required.
- If you're licensed in Idaho, skip to step #4; if you are **NOT** licensed in Idaho:
 - Type the name of the state where you are licensed in the "State licensed in if not in Idaho" field (if you're not licensed in Idaho, an answer is required).
 - Type the license number in the "Other State License" field (if you're not licensed in Idaho, an answer is required).
- Select "Next" to proceed to the Provider Eligibility Details page.

Provider Eligibility Details (MU Step 2)

Use the step-by-step instructions below to complete this page.





Program Year:

Select the program year. This selection is only available if the current date is between January 1 and the end of March. This allows you to choose the previous program year during the three month period where you are allowed to attest for either program year. After the end of March, the program year will be defaulted to the current calendar year, which will be equal to the current active program year.

Patient Volume:

- 1. Select "Yes" or "No" from the drop down menu to indicate if your patient volume was calculated using the group proxy method.
- 2. If you answered "Yes", enter the NPI of the proxy entity (Idaho Medicaid will verify the NPI). If you entered "No", skip to question #3.
- 3. Select the starting date of the 90-day period to calculate the Medicaid/needy patient encounter volume percentage. If you do not enter a valid date, you will not be allowed to continue with attestation.
 Note: The date must be a valid date within the previous calendar year or rolling calendar year to 90 days before the current date (January 1 to 90 days before the current date). This accommodates the EP's choice of using the previous calendar year or the most recent 12 months for the 90-day patient volume period.

4. Enter the Medicaid/needy patient encounters during this period.

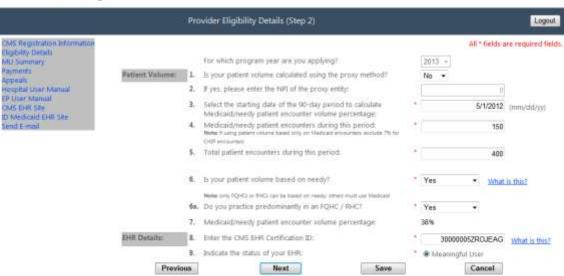
Note: If using patient volume based only on Medicaid encounters, exclude seven percent for CHIP encounters. If you are basing patient volume on needy, disregard the exclusion of CHIP encounters. The following is an example for excluding CHIP encounters for patient volumes based on Medicaid:

- Total Medicaid encounters = 120
- Calculated CHIP amount based on seven percent state average: 8.4 and round to the nearest whole number 8
- Net Medicaid encounters: 120 8 = 112
- Result: use 112 for the Medicaid patient encounters
- 5. Enter the number of total patient encounters during this period.
- There are two options for this question. Please read both options before completing this question.

Option #1: If you are basing your patient volume on needy encounters, select "Yes" from the drop down menu and answer question 6a when it appears (see graphic below). **Only FQHCs or RHCs can be based on needy; others must use Medicaid encounters.**

6a. Select "Yes" or "No" from the drop down menu to indicate if you practice predominantly at an FQHC or RHC (see graphic below). If you don't practice predominantly in an FQHC or RHC, you will not be allowed to continue with attestation.





Option #2: If you are not basing your patient volume on needy encounters, select "No" from the drop down menu and answer question 6b (see graphic below) when it appears.

6b. Use the drop down menu to indicate if you are **NOT** hospital based. If you are hospital based, you will not be allowed to continue with attestation.





7. Medicaid/needy patient volume percentage (calculated).

Note: When items #4 and #5 are entered and the cursor is moved to the next entry, the patient volume percentage is displayed.

The following edits with messages apply, if you do not meet these thresholds, you will not be allowed to continue with attestation.

- If the provider specialty is pediatrics and patient volume is based on Medicaid volumes but is below the 20 percent patient volume threshold, this message will be displayed: "x.xx% you must meet the threshold of 20% to get an EHR Incentive Payment".
- For other provider specialties (regardless of how patient volume is based) and those below the 30 percent patient volume threshold, this message will be displayed: "x.xx% you must meet the threshold of 30% to get an EHR Incentive Payment".

EHR Details:

- 8. Enter the CMS EHR Certification ID of your EHR:
 - This is your CMS EHR Certification ID, which will be auto-populated from your CMS registration information, if it was provided there. If not, the EHR Certification ID must be input here. Only a valid ID will be allowed for you to continue your attestation.
- 9. Indicate the status of your EHR: Select "Meaningful User".

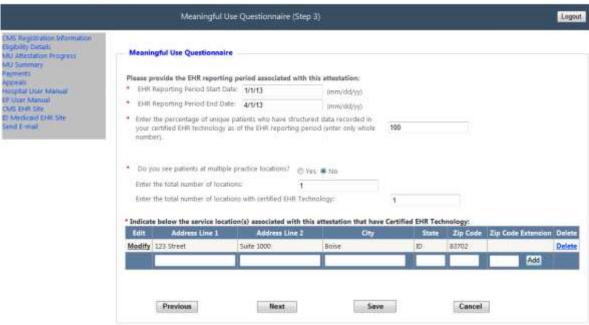
After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" Will save your entries and take you to the Meaningful Use Questionnaire page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Meaningful Use Questionnaire (MU Step 3)

Use the step-by-step directions below to complete this page. **Note:** A red asterisk indicates a required field.





EHR Reporting Period:

- Enter the EHR reporting period start date in the following format: MM/DD/YY.
- Enter the EHR reporting period end date in the following format: MM/DD/YY.

You will receive an error message if:

- The reporting period you enter is not a period of at least 90 days.
- The start date is not at least 90 days before the current date.
- The end date is not earlier than the current date.

Percentage of Unique Patients with Structured Data:

 Enter the percentage of unique patients who have structured data recorded in your certified EHR technology as of the EHR reporting period. Note: Only enter whole numbers.

You will receive an error message if:

The number you enter is not a whole number greater than 80 and no greater than 100.

Location Addresses:

- Select "Yes" or "No" to indicate if you have multiple practice locations.
- If you select "Yes", type the total number of locations (if you select "No", the box will auto populate the number "1").
- Enter the total number of locations indicated that have adopted, implemented, or upgraded to certified EHR technology.
- Use the table provided to fill in the address, city, state, and ZIP code for each service location indicated.
 Click "Add" after each location entered.

Note: you may modify or delete your entries.

You will receive an error message if:

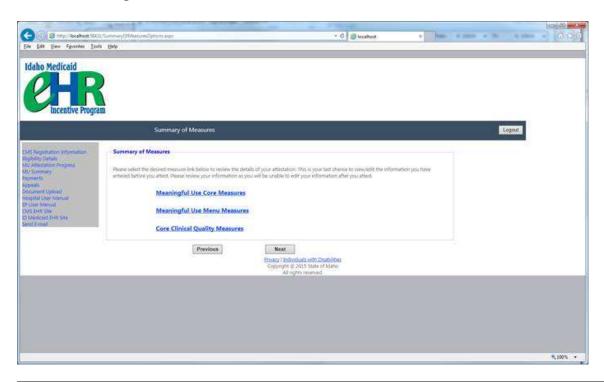
- You select "Yes" to indicate that you have multiple practice locations but leave any of the other fields blank (if you select "Yes", all fields on this page are required).
- The total number of locations with certified EHR technology is greater than the total number of service locations entered.
- The number of service locations that have certified EHR technology (the number entered in the second box) is different from the number of location addresses typed in the table (e.g., if you indicate that you have 5 service locations with certified EHR technology, you must enter 5 physical addresses into the table).

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" Will save your entries and take you to the Summary of Menu Options page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Summary of Menu Options (MU Step 4)

The Summary of Menu Options page shows the progression through attestation. You can review this page periodically by clicking on the "MU Summary" link on the left side menu. As you progress through the sections the categories on the page will become hyperlinks so you can quickly return to where you left off when you are done reviewing.



When this page appears:

Select "Next" to proceed to the Meaningful Use Core Measures page.

Meaningful Use Core Objectives (MU Step 5)

Below is a list of core objectives EPs must either meet or claim an exemption for to qualify for an EHR incentives payment. After you enter the data for each objective, click next and it will save the data and progress you through to the next objective. If you would like to save the data and exit the screen, you must click "save". If you click "back" or "previous" you data will not be saved.

Stage 1 Core Objectives

- 1. Computerized provider order entry (CPOE)
- 2. E-Prescribing (eRx)
- 3. Implement one clinical decision support rule
- 4. Provide patients the ability to view online, download, and transmit information within four business days of the information being available to the EP
- 5. Provide clinical summaries for patients for each office visit
- 6. Drug-drug and drug-allergy interaction checks
- 7. Record demographics
- 8. Maintain an up-to-date problem list of current and active diagnoses
- 9. Maintain active medication list
- 10. Maintain active medication allergy list
- 11. Record and chart changes in vital signs
- 12. Record smoking status for patients 13 years or older
- 13. Protect electronic health information

Stage 2 Core Objectives

- 1. Use computerized provider order entry (CPOE) for medication, laboratory, and radiology orders
- 2. Generate and transmit permissible prescriptions electronically (eRx)
- 3. Record demographic information
- 4. Record and chart changes in vital signs
- 5. Record smoking status for patients 13 years old or older
- 6. Use clinical decision support to improve performance on high-priority health conditions
- 7. Provide patients the ability to view online, download, and transmit their health information
- 8. Provide clinical summaries for patients for each office visit
- 9. Protect electronic health information created or maintained by Certified EHR Technology
- 10. Incorporate clinical lab-test results into Certified EHR Technology
- 11. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach
- 12. Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care
- 13. Use certified EHR technology to identify patient-specific educational resources
- 14. Perform medication reconciliation
- 15. Provide summary of care record for each transition of care or referral
- 16. Submit electronic data to immunization registries
- 17. Use secure electronic messaging to communicate with patients on relevant health information

After entering your data for the Core Objectives, you must select one of the following buttons from the bottom of the screen:

- "Previous" If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" Will save your entries and take you to the Electronic Data to Immunization Registries page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" Will replace any changes you made with data retrieved from the last time you saved your
 information. For example, if you never entered anything into the page before selecting "Cancel" you
 will see blank fields.

Meaningful Use Menu Measures (MU Step 6)

Below is a list of menu objectives. EPs participating in Stage 1, must choose 5 menu objectives out of a list of 9 menu objectives. At least one of these measures must be from the Public Health Measure list. EPs participating in Stage 2, must choose 3 objectives out of a list of 6 menu objectives. After you enter the data for each objective, click next and it will save the data and progress you through to the next objective. If you would like to save the data and exit the screen, you must click "save". If you click "back" or "previous" you data will not be saved.

Stage 1 Menu Objectives

- 1. Implement drug formulary checks
- 2. Incorporate clinical lab-test results into EHR as structured data
- Generate lists of patients by specific conditions to use for quality improvement, reductions of disparities, research, or outreach
- 4. Send patient reminders per patient preference for preventive/follow-up care
- 5. Use certified EHR technology to identify patient-specific education resources and provider those resources to the patient if appropriate
- 6. The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation
- 7. The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary of care record for each transition of care or referral
- 8. Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.
- 9. Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice

Stage 2 Menu Objectives

- 1. Submit electronic syndromic surveillance data to public health agencies
- 2. Record electronic notes in patient records
- 3. Imaging results accessible through CEHRT
- 4. Record patient family health history
- 5. Report cancer cases to a public health central cancer registry
- 6. Report specific cases to a specialized registry

Important Note: While there are exclusions provided for some of these menu objectives, you cannot select a menu objective and claim the exclusion if there are other menu objectives that you could report on instead.

After entering your data for the Menu Objectives, you must select one of the following buttons from the bottom of the screen:

• "Previous" - If you have not saved your entries, this will cancel your entries and take you to the

previous page.

- "Next" Will save your entries and take you to the Electronic Data to Immunization Registries page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Clinical Quality Measures (MU Step 7)

Providers must report on 9 clinical quality measures (CQM) from a list of 64 clinical quality measures from 3 of 6 domains. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero. After you enter the data for each CQM, click next and it will save the data and progress you through to the next CQM. If you would like to save the data and exit the screen, you must click "save". If you click "back" or "previous" you data will not be saved.

Domain 1: Clinical Process/Effectiveness

0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
0018	Controlling High Blood Pressure
0031	Breast Cancer Screening
0032	Cervical Cancer Screening
0034	Colorectal Cancer Screening
0036	Use of Appropriate Medications for Asthma
0043	Pneumonia Vaccination Status for Older Adults
0055	Diabetes: Eye Exam
0056	Diabetes: Foot Exam
0059	Diabetes: Hemoglobin A1c Poor Control
0060	Hemoglobin A1c Test for Pediatric Patients
0062	Diabetes: Urine Protein Screening
0064	Diabetes: Low Density Lipoprotein (LDL) Management
0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
0070	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left
	Ventricular Systolic Dysfunction (LVEF <40%)
0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
0081	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor
	Blocker(ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
0086	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of
	Severity of Retinopathy
0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
0104	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
0105	Anti-depressant Medication Management
0108	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD)
	Medication
0110	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
0385	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients
0387	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR)
	Positive Breast Cancer
0403	HIV/AIDS: Medical Visit
0405	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis

Domain 1: Clinical Process/Effectiveness (cont'd)

	• • • • • • • • • • • • • • • • • • • •
TBD	HIV/AIDS: RNA Control for Patients with HIV
0565	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
608	Pregnant women that had HBsAg testing
0710	Depression Remission at Twelve Months
0712	Depression Utilization of the PHQ-9 Tool
TBD	Children Who Have Dental Decay or Cavities
TBD	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists
TBD	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed
TBD	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)
TBD	Dementia: Cognitive Assessment
TBD	Hypertension: Improvement in Blood Pressure

Domain 2: Patient Safety

0022	Use of High-Risk Medications in the Elderly
0101	Falls: Screening for Future Fall Risk
0419	Documentation of Current Medications in the Medical Record
0564	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical
	Procedures
1365	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
TBD	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range

Domain 3: Efficient Use of Healthcare Resources

0002	Appropriate Testing for Children with Pharyngitis
0069	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
0052	Use of Imaging Studies for Low Back Pain

Domain 4: Population/Public Health

0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
0033	Chlamydia Screening for Women
0038	Childhood Immunization Status
0041	Preventive Care and Screening: Influenza Immunization
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
1401	Maternal Depression Screening
TBD	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Domain 5: Patient and Family Engagement

0384	Oncology: Medical and Radiation – Pain Intensity Quantified
TBD	Functional Status Assessment for Knee Replacement
TBD	Functional Status Assessment for Hip Replacement
TBD	Functional Status Assessment for Complex Chronic Conditions

Domain 6: Care Coordination

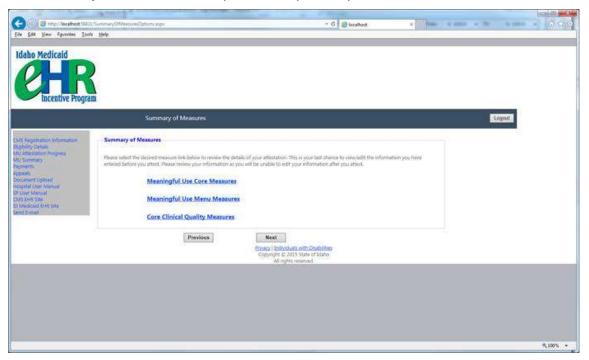
TBD Closing the Referral Loop: Receipt of Specialist Report

After entering your data for the CQMs, you must select one of the following buttons from the bottom of the screen:

- "Previous" If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" Will save your entries and take you to the Electronic Data to Immunization Registries page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

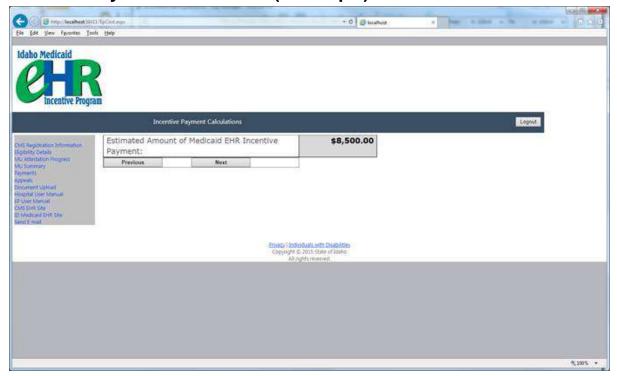
Summary of Measures (MU Step 8)

After the last clinical quality measure, you will see the Summary of Measures page. This page allows you to return to a major section and edit any individual question you have answered.



Note: Selecting "Previous" prior will result in moving to the previous link of the "Summary of Measures" link (e.g., Meaningful Use Menu Measures Summary). If the user clicks on "Next" the Incentive Payment Calculations page will display.

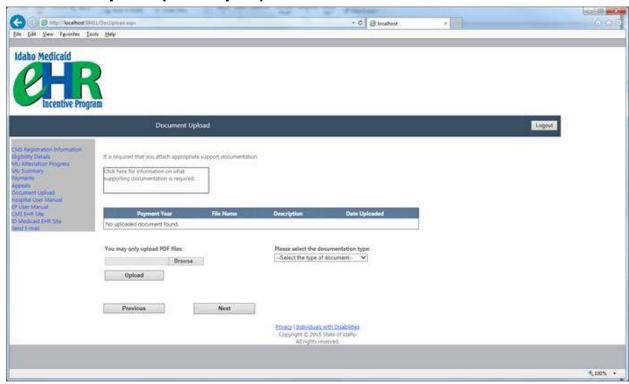
Incentive Payment Calculations (MU Step 9)



When this page appears:

- Review the incentive payment amount. Contact the Idaho Medicaid EHR Incentive Program Help Desk if you have questions.
- If you see a \$0 estimated amount of Medicaid EHR incentive payment, you may not have met eligibility requirements; click on the "Previous" button, which will take you back to the Provider Eligibility Details page, and check your responses to the questions. If you have questions, contact the Help Desk at EHRincentives@dhw.idaho.gov or call (208) 332-7989.
- If your payment amount looks correct, select "Next" to go to the Document Upload page.

Document Upload (MU Step 10)



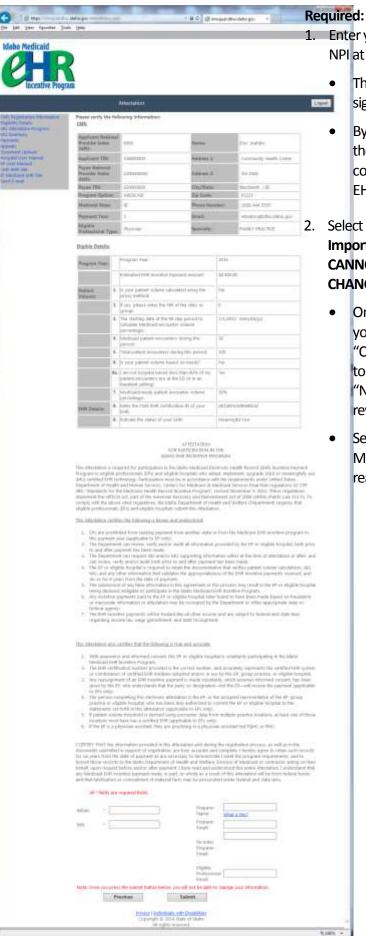
When this page appears:

In addition to the Meaningful Use documentation listed below, you will also be required to upload your
patient volume report and proof of EHR purchase/upgrade (copy of current paid invoice, cancelled check,
etc.).

Note: Only PDF files can be uploaded.

- You will still be able to upload files even after you have completed your attestation.
- Selecting "Next" will take you to the Attestation page of the IIMS.
- Meaningful use documentation
 - Core Measures: One de-identified report from the certified EHR software that was used for a core attestation item
 - Menu Measures: One de-identified report from the certified EHR software that was used for a menu attestation item
 - Clinical Quality Measures: One de-identified report from the certified EHR software that was used for a clinical quality measure attestation item
 - When naming your document, please use the following naming conventions:
 - Provider last name_Core/Menu/CQM#_date (e.g., Smith_CQM 0075_072114)

Attestation (MU Step 11)



 Enter your initials or name and the provider's NPI at the bottom of the screen.

- This will serve as your electronic signature.
- By entering this information, you attest to the validity of all data submitted for consideration by the Idaho Medicaid EHR Incentive Program.
- Select "Submit".

Important: After you select "Submit", YOU CANNOT GO BACK AND MAKE ANY CHANGES.

- Once you select "Submit", it will take you to the first page of your attestation, "CMS Registration Information (Step 1)", to review. You can select "Previous" and "Next" to view the attestation pages in a review mode only.
- Selecting "Submit" will notify Idaho
 Medicaid that the provider's attestation is ready for final eligibility review.

The attestation text is shown here:

ATTESTATION

FOR PARTICIPATION IN THE

IDAHO MEDICAID EHR INCENTIVE PROGRAM

This Attestation is required for participation in the Idaho Medicaid Electronic Health Record (EHR) Incentive Payment Program to eligible professionals (EPs) and eligible hospitals who adopt, implement, upgrade (AIU), or meaningfully use (MU) certified EHR technology. Participation must be in accordance with the requirements under United States Department of Health and Human Services, Centers for Medicare & Medicaid Services Final Rule regulations 42 CFR 495, "Standards for the Electronic Health Record Incentive Program", revised July 28, 2010. These regulations implement the HITECH Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5). To comply with the above cited regulations, the Idaho Department of Health and Welfare (Department) requires that EPs and eligible hospitals submit this Attestation.

This Attestation certifies the following is known and understood:

- 1. EPs are prohibited from seeking payment from another state or from the Medicare EHR incentive program in this payment year (applicable to EP only).
- The Department can review, verify, and/or audit all information provided by the EP or eligible hospital, both prior to and after payment has been made.
- 3. The Department can request AIU and/or MU supporting information either at the time of attestation or after, and can review, verify, and/or audit both prior to and after payment has been made.
- 4. The EP or eligible hospital is required to retain the documentation that verifies patient volume calculations, AIU, MU, and any other information that validates the appropriateness of the EHR incentive payments received, and do so for six years from the date of payment.
- 5. The submission of any false information in this agreement or this process may result in the EP or eligible hospital being declared ineligible to participate in the Idaho Medicaid EHR Incentive Program.
- 6. Any incentive payments paid to the EP or eligible hospital that are later found to have been made based on fraudulent or inaccurate information or attestation may be recouped by the Department or other appropriate state or federal agency.
- 7. The EHR incentive payments will be treated like all other income and are subject to federal and state laws regarding income tax, wage garnishment, and debt recoupment.

This Attestation also certifies that the following is true and accurate:

- 1. With awareness and informed consent, this EP or eligible hospital is voluntarily participating in the Idaho Medicaid EHR Incentive Program.
- 2. The EHR certification number provided is the correct number and accurately represents the certified EHR system or combination of certified EHR modules adopted and/or in use by this EP, group practice, or eligible hospital.
- 3. Any reassignment of an EHR incentive payment is made voluntarily, which assumes informed consent has been given by the EP, who understands that the party so designated—not the EP—will receive the payment (applicable to EPs only).
- 4. The person completing this electronic attestation is the EP or the assigned representative of the EP, group practice, or eligible hospital who has been duly authorized to commit the EP or eligible hospital to the statements set forth in this attestation (applicable to EPs only).
- 5. If patient volume threshold is derived using encounter data from multiple practice locations, at least one of those locations must have a certified EHR (applicable to EPs only).
- If the EP is a physician assistant, he or she is practicing in a physician assistant led FQHC or RHC.

I CERTIFY THAT the information provided in this Attestation and during the registration process, as well as in the documents submitted in support of registration, are true, accurate, and complete. I hereby agree to retain such records for six years from the date of payment as are necessary to demonstrate I meet the program requirements, and to furnish those records to the Idaho Department of Health and Welfare, Division of Medicaid, or contractor acting on their behalf, upon request, before and/or after payment. I have read and understood this entire Attestation. I understand that any Medicaid EHR incentive payment made, in part or wholly as a result of this Attestation, will be from federal funds and that falsification or concealment of material facts may be prosecuted under federal and state laws.

Other Supporting Pages

The following pages are additional resources the provider may find useful when interacting with the Idaho Medicaid EHR Incentive Program.

The provider must be logged into the IIMS to see the left side menu items as shown below. The highlighted links will be described in the following pages.



Payments

To access this page, select "Payments" from the left side menu. After payment has been disbursed, the provider may review payments and any payment adjustments for each payment year they participated in Idaho's incentive program. If a provider participated in another state's Medicaid incentive program or the Medicare incentive program in other payment years, the information from those sources will not be made available here. The provider should be able to access that payment information from the other state's Medicaid incentive program's site or the CMS EHR Incentive Program Registration and Attestation System.





The payment details shows payments for the first two payment years, the amount paid and the payment type (initial for the program year or adjustment for the program year).

Appeals



Appeals

Logaut

CMS Registration information Eligibility Details Payments Appeals Hospital User Manual EP User Manual CMS EHR See D Medicaid EHR See Seed E-mail

Department of Health and Welfare Rules, IDAPA 16, Title 5, Chapter 3, Section 300, specifies your right to request an administrative review of any reimbursement calculation. The aforementioned procedures must be followed in order to preserve your appeal rights. The first step in that process is to request a review by the Administrator of the Division of Medicaid. Such a request should be addressed as follows:

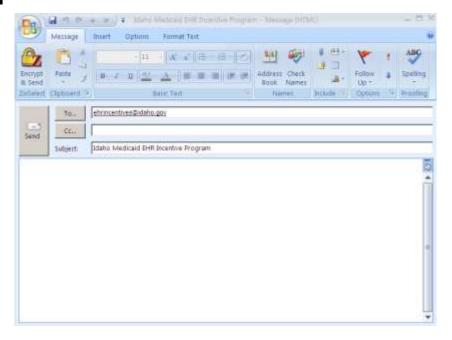
Administrator Division of Medicaid, Attn: Appeals Idaho Department of Health and Welfare P.O. Box 83720 Boise, Idaho 83720-0009

Your written request must be received by this office within twenty-eight (28) days of your receipt of a denial letter to be considered. If you have additional participant documentation that was available and relevant at the time of the request but not previously provided that you would like the Department to consider, please enclose it with your request for administrative review.

To access this page:

- Select "Appeals" from the left side menu.
- Review the information to ensure any appeals you would like to file are sent to the correct location.
 Note: A provider can only submit appeals in writing.

Send E-mail



To access this page:

- Select "Send E-mail" from the left side menu to initiate the e-mail application on the provider's computer.
 Note: This is the same as clicking on the "Send email to: EHRIncentives@dhw.idaho.gov" on the Idaho Medicaid EHR Incentive Program website.
- Enter the message and send the email.
 Note: If you have problems with your email system, please contact your local office's IT support for assistance before contacting the Idaho Medicaid EHR Incentive Program Help Desk.

APPENDIX

Resources

CMS Stage 2 Final Rule

A CMS website that provides the latest in final rules and overviews of Stage 2 Meaningful Use. http://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/stage 2.html

Medicare and Medicaid Electronic Health Records (EHR) Incentive Program

The CMS website with information about EHR incentives and how to get started to register for the incentive program http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/

Eligible Professional and Eligible Hospital Attestation Portal for Idaho

Idaho Incentive Management System (IIMS) where you may log in and begin to attest is located at http://www.MedicaidEHR.dhw.idaho.gov.

Office of the National Coordinator for Health Information Technology (ONC)

Certified Health IT Product List (CHPL):

http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl

Regional Extension Centers (RECs)

The Washington Idaho Regional Extension Center (WIREC) is designated to provide technical assistance to Idaho's eligible professionals. WIREC provides a full range of assistance related to EHR selection and training.

Qualis Health PO Box 33400

Seattle, WA 98133-0400

Phone: (206) 364-9700 Toll-free: (800) 949-7536

Fax: (206) 366-3370 http://www.wirecqh.org/ Peggy Evans, PhD, CPHIT

WIREC Director

peggye@qualishealth.org

(206) 288-2471

Kristin Johnson

WIREC Project Coordinator kristinj@qualishealth.org

(206) 288-2357

Frequently Asked Questions About Using a Provider Roster

Is using a group proxy required?

The Medicaid EHR Incentive Program does not require an EP to use one method of patient volume calculation over the other. All EPs are free to use an individual patient volume calculation or a group proxy calculation. All EPs are encouraged to talk with their clinic's or organization's administration as they may have a preference.

What's the best way to establish a group proxy approach?

All EPs participating in the Medicaid EHR Incentive Program from a clinic/organization must use the same approach for any given calendar year to meet patient volume requirements. The first provider approved for payment will set the approach for the clinic/organization. For example:

- If the first provider participating from a clinic/organization attests to individual patient volumes (and is approved for payment), all providers subsequently participating for that calendar year from that clinic/organization will be required to attest to individual patient volumes and are not allowed to use a group proxy at either the organization or clinic level.
- If the first provider enrolling from a clinic/organization attests to the group proxy calculation for the clinic/organization, subsequent providers associated with that clinic/organization are required to attest to the same overall patient volumes using the same group proxy worksheet. They will not be given the opportunity to use individual patient volumes.

Is there an example of a group proxy calculation?

The following excerpt from the CMS FAQ# 2293 illustrates how the group proxy calculation is to be applied:

If an eligible professional (EP) in the Medicaid EHR Incentive Program wants to leverage a clinic or group practice's patient volume as a proxy for the individual EP, how should a clinic or group practice account for EPs practicing with them part-time and/or applying for the incentive through a different location (e.g., where an EP is practicing both inside and outside the clinic/group practice, such as part-time in two clinics)?

EPs may use a clinic or group practice's patient volume as a proxy for their own under three conditions:

- 1. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (e.g., if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
- 2. There is an auditable data source to support the clinic's patient volume determination; and
- 3. So long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

In order to provide examples of this answer, please refer to Clinics A and B, and assume that these clinics are legally separate entities.

If Clinic A uses the clinic's patient volume as a proxy for all EPs practicing in Clinic A, this would not preclude the part-time EP from using the patient volume associated with Clinic B and claiming the incentive for the work performed in Clinic B. In other words, such an EP would not be required to use the patient volume of Clinic A simply because Clinic A chose to invoke the option to use the proxy patient volume. However, such EP's Clinic A patient encounters are still counted in Clinic A's overall patient volume calculation. In addition, the EP could not use his or her patient encounters from clinic A in calculating his or her individual patient volume.

The intent of the flexibility for the proxy volume (requiring all EPs in the group practice or clinic to use the same methodology for the payment year) was to ensure against EPs within the same clinic/group practice measuring patient volume from that same clinic/group practice in different ways. The intent of these conditions was to prevent high Medicaid volume EPs from applying using their individual patient volume, where the lower Medicaid patient volume EPs then use the clinic volume, which would of course be inflated for these lower-volume EPs.

CLINIC A (with a fictional EP and provider type)

- EP #1 (physician): individually had 40% Medicaid encounters (80/200 encounters)
- EP #2 (nurse practitioner): individually had 50% Medicaid encounters (50/100 encounters)
- Practitioner at the clinic, but not an EP (registered nurse): individually had 75% Medicaid encounters (150/200)
- Practitioner at the clinic, but not an EP (pharmacist): individually had 80% Medicaid encounters (80/100)
- EP #3 (physician): individually had 10% Medicaid encounters (30/300)
- EP #4 (dentist): individually had 5% Medicaid encounters (5/100)
- EP #5 (dentist): individually had 10% Medicaid encounters (20/200)

In this scenario, there are 1200 encounters in the selected 90-day period for Clinic A. There are 415 encounters attributable to Medicaid, which is 35% of the clinic's volume. This means that 5 of the 7 professionals would meet the Medicaid patient volume criteria under the rules for the EHR Incentive Program. (Two of the professionals are not eligible for the program on their own, but their clinical encounters at Clinic A should be included.)

The purpose of these rules is to prevent duplication of encounters. For example, if the two highest volume Medicaid EPs in this clinic (EPs #1 and #2) were to apply on their own (they have enough Medicaid patients to do that), the clinic's 35% Medicaid patient volume is no longer an appropriate proxy for the low-volume providers (e.g., EPs #4 and #5).

If EP #2 is practicing part-time at both Clinic A, and another clinic, Clinic B, and both Clinics are using the clinic-level proxy option, each such clinic would use the encounters associated with the respective clinics when developing a proxy value for the entire clinic. EP #2 could then apply for an incentive using data from one clinic or the other.

Similarly, if EP #4 is practicing both at Clinic A, and has her own practice, EP #4 could choose to use the proxy-level Clinic A patient volume data, or the patient volume associated with her individual practice. She could not, however, include the Clinic A patient encounters in determining her individual practice's Medicaid patient volume. In addition, her Clinic A patient encounters would be included in determining such clinic's overall Medicaid patient volume.

Related FAQs From CMS's Website Regarding Getting EHR Certification

How do I know if my EHR system is certified? How can I get my EHR system certified? The following excerpt is from CMS FAQ #2811.

The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology, as established by a new set of standards and certification criteria. Existing EHR technology needs to be certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) to meet these new criteria in order to qualify for the incentive payments. The Certified Health IT Product List (CHPL) is available at http://www.healthit.hhs.gov/CHPL. This is a list of complete EHRs and EHR modules that have been certified for the purposed of this program.

Through the temporary certification program, new certification bodies have been established to test and certify EHR technology. Vendors can submit their EHR products to the certifying bodies to be tested and certified. Hospitals and practices who have developed their own EHR systems or products can also seek to have their existing systems or products tested and certified. Complete EHRs may be certified as well as EHR modules that meet at least one of the certification criteria. Once a product is certified, the name of the product will be published on the ONC web site: http://www.healthit.hhs.gov/CHPL.

Must providers have their EHR technology certified prior to beginning the EHR reporting period in order to demonstrate meaningful use under the Medicare and Medicaid EHR Incentive Programs? The following excerpt is from CMS FAQ #2893.

No. An EP or hospital may begin the EHR reporting period for demonstrating meaningful use before their EHR technology is certified. Certification need only be obtained prior to the end of the EHR reporting period. However, meaningful use must be completed using the capabilities and standards outlined in the ONC Standards and Certification Regulation for certified EHR technology. Any changes to the EHR technology after the beginning of the EHR reporting period that are made in order to get the EHR technology certified would be evidence that the provider was not using the capabilities and standards necessary to accomplish meaningful use because those capabilities and standards would not have been available, and thus, any such change (no matter how minimal) would disqualify the provider from being a meaningful EHR user. If providers begin the EHR reporting period prior to certification of their EHR technology, they are taking the risk that their EHR technology will not require any changes for certification. Any changes made to gain certification must be done prior to the beginning of the EHR reporting period during which meaningful use will be demonstrated. This does not apply to changes made to EHR technology that were not necessary for certification.

My EHR system is CCHIT certified, does that mean it is certified for the EHR Incentive Programs? The following excerpt is from CMS FAQ #2623.

No. All EHR systems and technology must be certified specifically for this program. The Certified Health IT Product List is available at http://www.healthit.hhs.gov/CHPL. This is a list of all complete EHRs and EHR modules that have been certified for the purposes of this program.

The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology, as established by a new set of standards and certification criteria. Existing EHR technology needs to be certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) to meet these new criteria in order to qualify for the incentive payments.

Through the temporary certification program, new certification bodies have been established to test and certify EHR technology. Vendors can submit their EHR products to the certifying bodies to be tested and certified. Hospitals and practices who have developed their own EHR systems or products can also seek to have their existing systems or products tested and certified. Complete EHRs may be certified as well as EHR modules that meet at least one of the certification criteria. Once a product is certified, the name of the product will be published on the ONC web site – http://www.healthit.hhs.gov/CHPL.

If a provider purchases a certified complete EHR or has a combination of certified EHR modules that collectively satisfy the definition of certified EHR technology, but opts to use a different, uncertified EHR technology to meet certain meaningful use core or menu set objectives and measures, will that provider be able to successfully demonstrate meaningful use under the Medicare and Medicaid EHR Incentive Programs? The following excerpt is from CMS FAQ #3211.

No, the EP would not be able to successfully demonstrate meaningful use. To successfully demonstrate meaningful use, a provider must do three things:

- 1. Have certified EHR technology capable of demonstrating meaningful use, either through a complete certified EHR or a combination of certified EHR modules;
- 2. Meet the measures or exclusions for 17 meaningful use objectives (19 objectives for eligible hospitals and Critical Access Hospitals (CAHs)); and
- 3. Meet those measures using the capabilities and standards that were certified to accomplish each objective.

A provider using uncertified EHR technology to meet one or more of the core or menu set measures would not be using the capabilities and standards that were certified to accomplish each objective. Please note that this does not apply to the use of uncertified EHR technology and/or paper-based records for purposes of reporting on certain meaningful use measures (i.e., measures other than clinical quality measures), which is addressed in FAQ #10589.

Additional Information

If you have questions or issues concerning the Idaho Medicaid EHR Incentive Program, please visit www.MedicaidEHR.dhw.idaho.gov. There you will find an "Ask the Program" feature that will allow you to send questions to program staff. You can also e-mail questions to EHRIncentives@dhw.idaho.gov or call (208) 332-7989. You may also visit the Idaho Medicaid EHR website (www.MedicaidEHR.dhw.idaho.gov) or CMS's website (http://www.healthit.hhs.gov) for additional FAQs.